euchinin gr. xv once a day. On October 30th he returned to me to report that he had had no fever after the second dose. He said that he was taking a supply of euchinin back to Cayenne with him. He had some tinnitus, but not much.

CASE V.—November 8th, 1897. Rev. —, European, had tertian ague. He was ordered euchinin gr. xv once a day. The fever left after first dose, and did not return. He found it "stronger" than quinine, and said that half the dose was sufficient to keep away ague, while even that caused noises in the ears.

I have used euchinin in many other cases, but they are all similar to the above. To sum up:

1. Euchinin is as effective as quinine in malarial fever.
2. It causes cinchonism.
3. It is tasteless, therefore easily administered. This is its great advantage over quinine.

The readiest form of administering euchinin is the simple powder placed dry on the tongue and washed down by a little water. As it is very bulky, some patients prefer it in cachets; but all solutions of euchinin that I have seen are decidedly bitter, presenting no advantage whatever over quinine.

I do not consider cinchonism such a fatal objection as the intensely bitter taste of quinine. My experience of malarial fevers is that quinine and the malarial poison being antidotes to one another, cinchonism is the sign that a sufficient quantity of quinine has been taken to overcome its antagonist the malarial poison, as mercurialism is the sign that the syphilitic poison is under control.

If euchinin can be proved to be even nearly as effectual as quinine, its tastelessness alone should recommend it to many as a substitute, notwithstanding that it is not altogether free from some of the other objections to quinine.

REMARKS ON A CASE OF HORSESHOE KIDNEY SIMULATING MALIGNANT DISEASE OF THE ABDOMEN.

By THOMAS OLIVER, M.A., M.D., F.R.C.P.,
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THE following case is reported with the view of directing attention to the simulation of malignant disease by an abnormal kidney, and of the need for physicians and surgeons giving consideration to the possibility of the existence of such an abnormality before undertaking an exploration of the abdominal cavity. In most cases it must be that the existence of a horseshoe kidney is diagnosed only after the abdomen is opened. It was so in my own patient in whom there were no physical signs that strongly suggested such an abnormality.

Wm. K., aged 51 years, a coal miner, was admitted into the Royal Infirmary, Newcastle-upon-Tyne, complaining of headache and loss of appetite of seven years' duration, and of pain over the region of the stomach and down the spine of two months' duration. There is nothing in the family history that calls for comment. He has been married thirty-one years, is the father of eleven children, one of whom died in infancy. His wife has had two miscarriages. He has had a good home and plenty of food: he has been a teetotaler for the last eighteen years. As he has suffered much from indigestion he has been extremely careful in regard to his diet, particularly within the last twelve months, taking principally rice, fish, milk, and fresh eggs, etc. At the age of 24 years he had pneumonia; seven years ago he had influenza, and for the last ten years he has been more or less a dyspeptic.

Two months ago, while hewing coal in the pit and working in a bent position, he was seized with pains in the region of the umbilicus. It was so severe that he felt faint and was obliged to lie down for a little. He could work no more that day on account of pain, which by degrees gradually subsided. Afterwards he only felt the pain after eating, and although it often made him feel sick it only caused him to vomit once about a month ago.

He is on the whole a well-nourished man, but he states that within the last few weeks he has lost flesh considerably. Myxœdema is well marked. He has the jaded look and mental depression so frequently observed in old dyspeptic subjects. His tongue is dirty brown and coated. Chest: Heart and lungs are healthy. Abdomen: On inspection very distinct pulsation can be observed over a circumscribed area of 2 ins in diameter just above the umbilicus. A hard rounded mass with smooth borders can be felt, through which apparently the pulsation of the aorta is being transmitted. The tumour lies rather to the right than to the left of the aorta, and is felt to move up and down with respiration. It is painful on deep pressure, but is not attended by any sickening sensation when handled nor by a feeling of faintness. As the patient lies on his back a soft blowing systolic murmur can be heard through the stethoscope placed a little above rather than either over the tumour or below it. On placing him in a sitting posture the pulsation can hardly be detected and no *bruit* is thus heard. Turned on his face there is no longer pulsation felt when the hand is placed in the umbilical region until it is plunged deeply in, and even then it is not very distinct. On auscultating the spine no *bruit* is heard nor is pain elicited on percussing the spinal column. The legs are well developed; the knee-joints are normal. The bowels are

regular and there is no trouble with the bladder. The urine is acid Specific gravity 1028, no albumen, no sugar.

A diagnosis was never really made. Taking into consideration the history of the case, the long continued dyspepsia, recent pain, the presence of a circumscribed solid tumour in the abdomen almost in the middle line and movable during respiration, the age of the patient and his emaciation, and the fact that the physical examination excluded aneurysm, it is only right to say that the probability of malignant disease suggested itself, although there was nothing that helped us to locate the tumour in any particular organ in the abdomen. It was a case in which there was a large element of doubt in the diagnosis, and as it was evident that medicine could do nothing but palliate, and as the patient on account of pain was unable to follow his employment, he himself pressed for an abdominal exploration so that his mind might be placed at rest. My surgical colleague agreeing with me that the operation would at any rate enable us to make a complete diagnosis, Mr. Williamson on July 27th, 1897, opened the abdomen by an incision 6 ins. in length slightly to the right of the middle line. After examining the contents of the cavity the tumour was found to be a horseshoe-shaped kidney, the central part of the arch of which was lying upon the aorta. The abdominal incision was at once stitched up and in ten days thereafter the patient was practically well again and has remained so since, having lost all his pain and other unpleasant symptoms.

The question naturally arises, Was the operation justifiable? The end justifies the means, and as the end obtained was the cure of the patient, mental and physical, quite apart from the making of a diagnosis, I have no hesitation in answering the question in the affirmative. It is more than likely that strain at work loosened the attachments of the kidney, and by pulling upon delicate nerves caused the severe pain and feeling of faintness. Probably it was in consequence of this strain that the arch of the fused kidneys became movable. The range of movement was extremely limited, up and down during respiration only, and in extent nothing like what is observed in ordinary floating kidney, which has frequently been mistaken for a tumour of the omentum or mesentery. The possibility of a horseshoe kidney misleading the physician in his diagnosis is thus alluded to by Mr. Henry Morris in *Surgical Diseases of the Kidney*, p. 104: "It might easily happen that a horseshoe kidney or two kidneys more or less completely fused and situated in the median line of the abdomen or in some part or other of the pelvis might give rise to the opinion that a morbid growth existed." It was rather a morbid growth than an abnormal organ which the physical signs and symptoms presented in my patient, and as one horseshoe kidney is met with in every 1,600 *post-mortem* examinations, the value of my remarks will be enhanced if they direct attention to the necessity of giving some consideration to the possibility of fused kidneys in the diagnosis of obscure tumours of the abdomen.

SYMMETRICAL PARTIAL DETACHMENT OF FINGER NAILS FROM THEIR MATRICES.

By J. STANLEY KELLETT SMITH, F.R.C.S.ENG.

THE accompanying photograph (p. 553) illustrates a curious condition of symmetrical partial detachment of the finger nails from their matrices.

The patient, a young married woman, aged 30, states that about a year ago, without any apparent cause, the skin beneath the free edges of the affected nails began to peel away in whitish shreds. This continued for three to four months, at the end of which period the excavations beneath the nails had reached their present limits.

The fingers attacked are the index, middle, and little fingers in each hand. The nails themselves are lustrous and healthy looking, growing with an even free edge, and presenting no scaly, fibrillar, or opaque appearance. Over the area of separation, into which a probe can easily be passed, the matrix looks glazed, and is cicatricial to the touch. So marked is the symmetry of the condition that not only are the corresponding nails in the two hands affected, but the